Getting Political: Racism and Urban Health

Reducing inequalities in health is now a major focus of urban health initiatives. Arline Geronimus has focused attention on the continuing excess mortality among African Americans and other peoples of color.[1] In a related article in this issue, she further examines the reasons for this persistent inequality.[2] It is impossible to have a frank discussion of inequality, let alone devote an entire issue of the Journal to urban health, without confronting the continuing blight of racism head on.

While most urban health studies "account" for race, few analyze the impact of racism.[3] US society has adopted a number of euphemisms, including "urban centers," "inner cities," and "ethnic minorities," that tend to obscure the central issue. "Ethnic minorities" is a particularly vexing term because of its dismissive connotation. In fact, these groups, separately or together, make up large portions of many US cities and as much as 80% or more of the population of the high poverty areas within these cities.[2] Geronimus previously reported that in 1990 only 1 of 3 Harlem boys and 2 of 3 Harlem girls aged 15 years could expect to live through middle age.[1] These figures, sobering as they are, cannot convey the depth of suffering and pain of loss for the affected individuals, families, and communities.

In trying to understand the reasons for the glaring disparities in health among different population groups, it is common epidemiologic practice to compare the characteristics and behaviors of the individuals within these groups. Geronimus argues, however, that identifying and modifying individual behaviors will not lead to lasting gains in life expectancies in disadvantaged communities.[2] Rather, the long established and growing health disparities are rooted in fundamental social structure inequalities, which are inextricably bound up with the racism that continues to pervade US society.

Historical Roots

The relationships between excess mortality and social class are nothing new.[4,5] Social inequality has historically been characterized both by income differences and by group oppression.[6] Groups that have suffered systematic oppression beyond income levels alone have been stigmatized variously according to religion, language, and national origin. In the United States, racism has been the primary form of group oppression, with deep and penetrating roots that are firmly entrenched in the founding and earliest history of the country. The genocide and bondage perpetrated on kidnapped Africans and generations of slaves, followed by more than a century of racial oppression after the Civil War, have effectively kept African Americans disproportionately near the bottom of the social pyramid.

Other groups that today bear the burdens of inequality were first dispossessed generations ago. Native peoples were slaughtered and forced onto reservations. Mexicans were disenfranchised and their land expropriated. Immigrants and ethnic nationalities fueled the expansionist US economic engine even as they were reviled and murdered in the workplace.[7] Indeed, the social and cultural institutions have grown for so long in the soil of racism that the effects of oppression can take place even when the roots cannot be seen.

Social Ties

Health and longevity cannot be separated from even the most basic aspects of economic and social life.[4] Nutrition, clothing, shelter, and primary medical care cannot be reliably obtained with substandard income. A safe and healthy environment is undermined by discrimination in housing policies and the siting of hazardous and foul facilities in poor neighborhoods.[8] Barriers to health resources are all but insurmountable where inferior education and compromised social networks limit dissemination and implementation.[9] Racism and other forms of group oppression aggravate all of these situations and in themselves are sources of substantial, unrelenting stress.[10]

The entrenched and seemingly intractable character of racism and ethnic discrimination developed independent of any conscious conspiracy. Predictable market forces reward and bolster discriminatory practices that have evolved with the social institutions through which the US economy operates. Opposing racism, discrimination, and inequality in words may be good public relations, but overturning them in practice is bad for business.[11]

Slogan or Goal?

"Eliminating racial disparities" has become a national health slogan, and a host of well-intentioned scientific programs and public health initiatives over the past several years have been spawned. The phrase rings with moral fervor. Yet, even as a full room of prevention researchers rose to their feet in support of these notions at a convention in Atlanta this February, both members of the Community Advisory Board from Harlem remained in their seats. When asked why, they were as incredulous as they were direct: Did we really believe this goal was possible?

Are we deceiving ourselves? Perhaps we have been talking among ourselves too long. A perusal of the op-ed section of the *New York Times* makes it abundantly clear that some powerful members of US society are not as convinced as the public health community purports to be that racial equality in health is even desirable, much less attainable.[11]

Redirecting the Task

Having raised the question of whether or not eliminating racial disparities in health is universally embraced, we return to the audience of this journal, namely, public health sympathizers, who want to take up the task. Because mortality and health in general will rarely diverge far from economic and social relations, "the only way to eliminate differentials in health is to address the underlying 'social inequalities that so reliably produce them.'"[2,12] How, then, do we go about this?

A Political Framework

One option lies in the uniquely political character that distinguishes public health from other health fields. A "population" is a group of individuals, defined variously, with dynamics that render it more than the collection of individual traits.[13,14] A "public" is further characterized here as a population with a given social, economic, and—above all—political structure. Early campaigners for public health, such as those in the sanitarian movement, took a political approach. Over the last century, as various scientific disciplines, notably epidemiology, developed within public health, some promoted the goal of depoliticizing methods in the quest of scientific objectivity.[15]

We see an important distinction between "public health" and "population health," the latter being aligned most closely with epidemiology, at least as our respective training has impressed upon us. At times, an epidemi-

Editor's Note. Please see related article by Geronimus (p 867) in this issue.

ologic effort to adjust for or equalize the effects of social and economic differences in order to examine other factors may be appropriate. On the other hand, we believe public health requires that these differences be explored and confronted.

Whether any science should be or even can be objective with regard to political considerations has been and will continue to be debated.[16,17] Nonetheless, perhaps more assuredly than for any other health field, public health can never be depoliticized without losing its very essence and effectiveness. This is particularly evident in the campaign to eliminate racial and ethnic disparities in health.

Political measures are needed to narrow the abysmal gap in health disparities. Movements of organized labor, women, African Americans, and others—separately and together—have won improvements through the strength of united action.[18] A determined desire to achieve equality in health makes obvious the need for political action to effect fundamental social change.

Restructuring Society

In her commentary in this issue, Geronimus asks whether efforts to combat racial and ethnic disparities will be able "to mitigate, resist, or undo."[2] The determination that the problem is structural—that is, integral to the social structure that has evolved—leads to the conclusion that any change less than structural will be ephemeral.

This does not mean that other public health efforts that might ameliorate or resist the effects of disparities should be abandoned. On the contrary, such work is essential to bring immediate relief to those in critical need. At the same time, such efforts help expose the structural root of the problems and bring about awareness of the need for political struggle among those at the greatest disadvantage. Awareness, however, is not automatic. Important contributions toward achieving equality and promoting better health for all are possible when public health professionals help make the connections between immediate tasks and more fundamental goals.

The Foundation of Urban Health

Racism has led to the concentration of oppressed groups in cities and in the segregated neighborhoods that are cities within cities. Identifying and confronting the role and effects of racism will help urban health researchers investigate the other intersections and interactions of social structure and physical structure that characterize urban life.

Cities and their constituent neighborhoods are a complex web of groups of individuals in relatively confined physical environments. As cities grow and change, social relations and physical systems evolve with an intricate interdependence and distinctive ecologies. The problems for health that people confront everywhere are intensified by the density and diversity of urban settings.

Some aspects of urban living—including the quality of the air and drinking water, the provision of sanitation and fire services, and the availability and affordability of medical care—have established connections to health. Traffic patterns, zoning laws, quality schools, and police practices are also intimately connected to health, even if the mechanisms have not been as carefully demonstrated to date. Indeed, it is hard to imagine a municipal service or plan that does not have an impact on a city's health.

Yet, health is rarely, if ever, taken into account when political decisions are made about physical structures and social services. Corporate executives act to maximize profits. Government bodies too often choose politically expedient means, which, not surprisingly, correspond to the interests of the wealthy and powerful. Those who are neither wealthy nor powerful are not consulted and rarely informed about projects and activities that dramatically affect their health and lives.[19]

Getting Political

Health professionals in general, and urban health specialists in particular, can expose the potential health impacts of private and public urban policy. Communities need to be informed of both dangers and opportunities. Health should be a high priority in the evaluation of any project. Policies that reinforce racism or perpetuate social inequalities that form the basis of health disparities should be decisively opposed.

People want to live healthy and full lives. Knowing about the broad health risks of government and commercial policies may motivate more people to get involved in political struggles and demand to be heard. Building coalitions and movements that equip the public to fight for public health is a meaningful way to "mitigate, resist, and undo" health disparities and to make urban health a real priority in action, not just a figure of speech. □

Hillel W. Cohen, DrPH
Mary E. Northridge, PhD, MPH

Hillel W. Cohen is with the Department of Epidemiology and Social Medicine, Albert Einstein College of Medicine, Bronx, NY. Mary E. Northridge is with the Harlem Health Promotion Center, Harlem, NY.

Requests for reprints should be sent to Hillel W. Cohen, DrPH, Department of Epidemiology and Social Medicine, Albert Einstein College of Medicine, Room 1302, Belfer Bldg, 1300 Morris Park Ave, Bronx, NY 10461 (e-mail: hicohen@aecom.yu.edu).

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